THE DIVISION OF HEALTH OF MISSOURI

FILED NOV 15 1957

STANDARD CERTIFICATE OF DEATH

37513

STATE FILE NUMBER 10537

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY
c. CITY OR TOWN Carterville — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 32 Route #1 (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LEON Middle NMN Last HAMPTON

4. DATE OF DEATH: Month, Day, Year NOV. 5, 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 27, 1914

9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool & Die Maker

10b. KIND OF BUSINESS OR INDUSTRY: Tool Mfg. Co.

11. BIRTHPLACE (City and state or country): Carterville, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Cleve Hampton

13b. MOTHER'S MAIDEN NAME: Minnie Nolen

14. NAME OF HUSBAND OR WIFE: Lorene Foster Hampton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 331-16-0773

17. INFORMANT: Mrs. Lorene Hampton Address: Carterville, Illinois

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POST GASTRECTOMY SEPTICEMIA — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) STAPHYLOCOCCUS AUREUS — 1 WEEK
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from OCT. 23, 1957, to NOV. 5, 1957 and last saw her/him alive on NOV. 5, 1957
Death occurred at 5:50 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. D. — 22b. ADDRESS Barnes Hospital — 22c. DATE SIGNED 11/6/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal — 23b. DATE 11-6-57 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION (City, town, or county) (State) Carterville, Illinois

24. FUNERAL DIRECTOR ADDRESS East St. Louis, Ill. — 25. DATE RECD. BY LOCAL REG. NOV 6 57 — 26. REGISTRAR'S SIGNATURE

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Not Embalmed ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed ..... Joseph J. Gaudy .....

Licensed Embalmer No. 7541

P. O. Address East St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.